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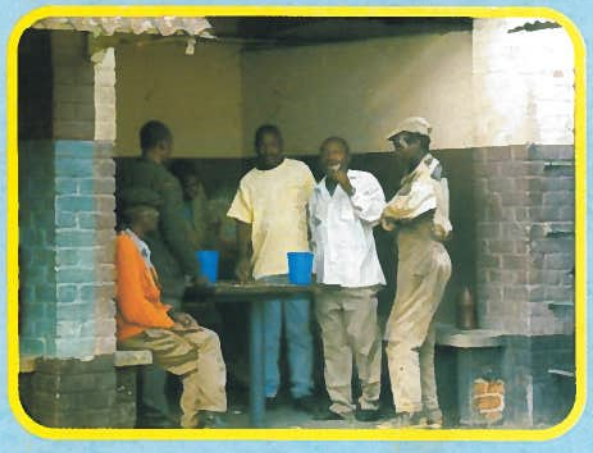
The National Female Condom Strategy 2006 to 2010



Ministry of Health and Child Welfare
Harare, Zimbabwe, 2006

Foreword

National HIV/AIDS Estimates 2005, show that of the 1391397 adults living with HIV, 56% are women. Preliminary findings of the Zimbabwe Demographic and Health Survey 2005 to 2006 also confirm the increasing feminization of the HIV epidemic, with a prevalence rate of 21% for adult females against 15% for adult males. This development highlights the need for and urgency of the increased promotion of an STI prevention method among other interventions that is initiated and controlled by women. Considering that choices to prevent HIV are limited, the female condom is the only available method which offers some degree of control to women who wish to protect themselves and their partners from the risk of STIs/HIV and unwanted pregnancy. The female condom is a tool that women can use to negotiate for safer sex as well as to facilitate communication with their partners about other reproductive health issues.

In September 2005, over one hundred stakeholders and experts met in Baltimore, Maryland, USA, to draw up a global strategy to bolster female condom programming and use worldwide. At this meeting, it was agreed that promotion of the female condom requires a new leadership at the global level involving coordination, cooperation and commitment to bring it fully forward as a protective barrier against HIV. Scaling up female condom programmes is critical to achieving the United Nations General Assembly 2005 Declaration of Universal Access to prevention and treatment to those who need it by 2010.

The Zimbabwe National AIDS Strategic Plan (ZNASP) 2006-2010 emphasizes the need for major efforts to make the female condom available to critical segments of the population, including married women and commercial sex workers. However, despite a successful launch in 1997, the female condom program, particularly in the public sector, faced supply problems as well as strategic direction challenges and thus has progressed little beyond the pilot stage for the past 9 years. In addition to erratic supplies, programming efforts of different stakeholders have been fragmented and uncoordinated.

In an effort to address the above, as well as work towards the goal of universal access, the MOHCW embarked on a highly consultative FC strategy development process. This process included a Female Condom Situation Analysis, conducted in September 2005, a Consultative Stakeholders' Meeting, held in Masvingo in March 2006, as well as a revision of the initial draft strategy circulated in October 2006. The Zimbabwe Female Condom Strategy 2006-2010, a product of that process, aims at providing a coordinated framework and guidance on female condom programming by all implementing partners in public, civil society and social marketing sectors, within the framework of the National Behavior Change Strategy 2006 - 2010 and the Zimbabwe National AIDS Strategic Plan 2006-2010.

The Ministry of Health and Child Welfare wishes to thank all organizations that participated in the strategy development process. Special recognition goes to the Technical Support Group (TSG) on Condom Programming, comprised of the National AIDS Council, the Zimbabwe National Family Planning Council, the Medicines Control Authority of Zimbabwe, Population Services International, the Zimbabwe AIDS Network, UNFPA, UNIFEM, UNAIDS, USAID, JSI Europe, JSI Deliver and DfID, for providing technical support for the development of the strategy. We look forward to continued support and guidance from the TSG as well as to cooperation between stakeholders in implementing this strategy.

Dr. E.T. Mabiza
Permanent Secretary For Health and Child Welfare
November 2006

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti- Retroviral Therapy
B	Behaviour Change
CBD	Community Based Distributor
CBO	Community Based Organizations
CSW	Commercial Sex Workers
CT	Counseling and Testing
DfID	Department for International Development
DAAC	District AIDS Action Committees
DHS	Demographic Health Survey
FBO	Faith Based Organization
FHCC	Family Health Care Centre
FP	Family Planning
HIV	Human Immunodeficiency Virus
MCAZ	Medicines Control Authority of Zimbabwe
M & E	Monitoring and Evaluation
NAC	National AIDS Council
NGO	Non Governmental Organization
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission of HIV
PSI	Population Services International
TSG	Technical Support Group on Condom Programming
UNAIDS	Joint United Nations Programme on AIDS
UNFPA	United Nations Population Fund
ZNASP	Zimbabwe National Strategic Framework
ZNFPC	Zimbabwe National Family Planning Council
ZNNP	Zimbabwe National Network of People Living with HIV and AIDS

1. Background and Context

With the HIV prevalence rate above 18%, the epidemic in Zimbabwe is acknowledged to be in a very advanced state. Additionally, specific sub-populations at risk continue to contribute disproportionately to the spread of HIV . Of the adult population aged 15 to 49 years living with HIV/AIDS in Zimbabwe, 56% are women. Biological and gender norms and relations, including practices related to sexuality, render women and girls more vulnerable to HIV infection than their male counterparts. Against this background the quote of Melinda Gates during the Global AIDS conference in 2006 in Toronto is particularly relevant: "No woman should have to seek her husband's permission to save her own life".

Whilst male condoms have been widely promoted and used for the prevention of sexual transmission of HIV, a significant proportion of the population is still left without protection. Socio-cultural traditions inhibit a large number of sexually active individuals from using the male latex condom as an effective means to protect themselves against Sexually Transmitted Infections (STI/HIV). It has been shown that reasons for non-use of the male condom vary with regard to age and type of relationship, but in particular married men and women, women in cross-generational sexual relationships, and couples with latex allergies, are not keen to utilize the male condom as a means of protection. The polyurethane female condom is a barrier method with a similar range of effectiveness as that of the male latex condom. It is a method that can be initiated by women and protects men and women who may choose to use it, or are unable to use the male latex condom to prevent STI/HIV. Against this background, introduction of the female condom in Zimbabwe took place more than 10 years ago.

While male condoms have been widely promoted and utilized, a significant proportion of the population is still left without protection.

First, an acceptability study on a small sample of family planning attendees in rural and urban areas and commercial sex workers was conducted in 1995. The results of this study found female condom acceptability to be over 50% among all categories of women. Consequently, the Women and AIDS Support Network mobilized 30,000 people, most of whom were women, to petition Government to introduce the female condom. The Ministry of Health and Child Welfare responded and the female condom was brought into the country.

In 1997 the female condom was made widely available through public sector outlets. Soon after this launch, the female condom public sector program conducted a pilot study in 30 districts (six of which were urban and 24 of which were rural). This study lasted for approximately one year and its results indicated 74% and 91% acceptability levels in men and women respectively. However, little progress was made beyond the initial study due to policy and programmatic constraints; especially limited stock availability made it impossible to meet the demand that had been created and a general lack of strategic direction and coordination marked the erratic nature of the public sector program. In 2002, new attempts were made to develop a targeted female condom strategy, but efforts again came to a standstill due to the inability to secure regular supplies. Despite significant envisaged potential, the public sector program failed to maintain a high degree of coverage.

[1]CSO, 2005 Zimbabwe Demographic and Health Survey, Preliminary Report
[2]MoHCW (2005) Zimbabwe National HIV/AIDS Estimates 2005- Preliminary Report
[3]Ray et al (1995) Acceptability of the Female Condom in Zimbabwe: Positive but Male Centred
[4]NACP- Ministry of Health and Child Welfare (1998) Piloting the Female Condom in Zimbabwe

On the other hand, as initial curiosity and interest drove people to try this new product, the social marketing program experienced a sudden increase in sales soon after introduction of the female condom in 1997. This trend later stabilized. PSI adopted a targeted marketing approach to the female condom in 2001 and has since expanded the social marketing program to married women, women living with HIV and AIDS, women in discordant relationships, and young females (aged 19-25). Annual distribution increased steadily between 2001 and 2005. In 2005, PSI expanded its channels to include groups of Commercial Sex Workers (CSW), groups of People Living with HIV/AIDS (PLWHA), Care and Support Organizations (CSO's) and tertiary institutions. Currently, sales continue to thrive.

Recognizing the need for a more strategic urban/rural and public/social marketing approach, UNFPA, in collaboration with the MoHCW, ZNFPC and PSI, facilitated the formation of a Technical Support Group on Condom Programming in 2005. The group - which is made up of representatives from Government institutions, NGOs, donor and UN agencies - is currently assisting Government to develop a five-year national male and female condom strategy. As part of this process, a Female Condom Research Review as well as a Female Condom Situation Analysis were conducted in 2005. Simultaneously, a large scale National Behavior Change Review was undertaken to provide results to guide evidence-based programming for the overall Prevention of Sexual Transmission of HIV. This review showed that whereas significant strides have been made in making male condoms available, and utilization in casual sexual relationships has increased significantly during the past 10 years, use of male condoms in stable relationships remains low.

Initial public sector efforts came to a standstill due to inability to secure regular supplies.

Findings from these review processes documents, together with recommendations from a National Female Condom Stakeholders meeting held in Masvingo in March 2006, will be incorporated as an integral part of the resulting National Male and Female Condom Strategy as well as the National HIV Behavior Change Strategy.

Chronology of events leading up to the National Female Condom Strategy 2006 - 2007

Year	Event
1995	First acceptability study of urban/rural family planning clients
1996	Women and AIDS Support Network mobilized 30,000 signatures to petition government to introduce the female condom.
1997	National Launch of the female condom
1998	Pilot study in 30 districts found high levels of acceptability (74% men and 91% women)
2001	Social marketing efforts began targeting specific segments of the population
1998-05	Public sector experienced supply problems and erratic trends
2002-05	Social marketing efforts registered steady gains in sales
2005	National HIV Behaviour Change Review Establishment of the Technical Support Group for condom programming, Female Condom Research Review Female Condom Situational Analysis
2006	National Female Condom Stakeholders meeting National RH Commodity Security Steering Committee secured regular condom supplies National Female Condom Strategy developed

2. Rationale and Guiding Principles

In Zimbabwe, like in most developing countries, the balance of the HIV and AIDS epidemic is weighing much more heavily on the side of women versus men, and married women are at a particular high risk of contracting the illness. Sexual transmission accounts for over 90% of HIV cases, followed by parent to child transmission, which in the majority of cases is indirectly caused by sexual contact as well.

With a well-designed strategy, the female condom has the potential of being adopted in marital and other stable sexual unions where condom use has traditionally been low.

Mechanical barrier methods to prevent sexual transmission have thus far been relatively limited to the male condom, with acceptance of the female condom occurring primarily in urban and peri-urban areas. The male latex condom has therefore been the only widely available mechanical barrier method for the prevention of STI/HIV as well as of pregnancy since chemical barrier methods such as microbicides are still under development.

Further rationale for developing the National Female Condom Strategy can be outlined as follows:

- Given its introduction as a "contraceptive sheath", and thus associated more with family planning than with STI/HIV, the female condom is relatively less stigmatized than the male condom.
- For pregnant and breastfeeding women, whose sexual union may only recommence after a relatively long time during which there may be increased chances for unfaithfulness by the male partner, the female condom provides protection from STI/HIV, both to the woman as well as to the unborn or breastfeeding baby.
- The female condom is a promising safer sex and contraceptive tool for women in rural settings, where couples are often separated when husbands migrate to urban areas in order to find employment. In those couples sexual reunion occurs only during sparse intermittent periods, which often are not considered long enough to maintain use of hormonal contraceptive methods.

"No woman should have to seek her husband's permission to save her own life."

- Preference of the female over the male condom was amply highlighted by HIV positive women during the Behavior Change Review, and when linked to Counseling and Testing (CT), has high chances of success in sero-discordant relationships.
- In the presence of latex allergies, the female condom is an important alternative for the male latex condom.
- With a well-designed strategy, the female condom has the potential of being adopted in marital and other stable sexual unions where condom use has traditionally been low.

Based upon these observations, it is highly recommended not only to scale up female condom programming but also to ensure that the initiatives of all stakeholders are focused and well coordinated in order to enhance synergies and avoid duplication of efforts.

[5] MoHCW (2004) The HIV Epidemic in Zimbabwe- Background, Projections, Impacts and Strategic Response
[6] CSO (1999) Demographic and Health Survey

The following principles are the base for a comprehensive strategy that guides coordinated female condom programming in both social marketing and public sectors:

- The Female Condom Strategy seeks to complement the existing male condom program and other safer sex strategies by increasing the overall number of protected sex acts.
- The Female Condom Strategy recognizes its connectedness with other programs and therefore shall be integrated into existing relevant HIV/AIDS Prevention and Reproductive Health Programs, including Prevention of Mother to Child Transmission (PMTCT), Counseling and Testing, Family Planning, Safe Motherhood initiatives, and RH Commodity Security initiatives.
- For acceptance, sustained use and impact of the female condom, it is important to engage men as partners and role models, as well as advocates for safer sex.
- People living with HIV/AIDS have a crucial role to play in female condom promotion and, where they have the relevant skills, must be involved at all levels in female condom programming.
- Women must be empowered with relevant knowledge and skills and shall have their rights in every sphere of life, including the right to safer sex, respected, in order to enable them to make informed choice regarding their reproductive health.
- Ultimately there should be universal access to female condoms in both urban and rural settings, across all economic strata, and through public and social market channels.

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3. Current Implementation Status

The following section outlines the major findings from the Female Condom Research Review and Situation Analysis, as well as from the HIV Behavior Change Review and other related literature:

3.1 Overview

Nine years after its launch in 1997, the female condom is now made available through two complementary systems: public sector distribution and social marketing systems.

The public sector female condom (unbranded) is intended for distribution through Government and quasi-government structures such as the Zimbabwe National Family Planning Council (ZNFPC) and local authority health care facilities. ZNFPC has been the focal point for public sector female condom warehousing and distribution. The Delivery Team Top Up (DTTU) system delivers condoms and other contraceptive supplies directly to service delivery points. Service delivery points include public sector health care centres (traditional outlets) and other Non-Governmental Organizations (NGO's), Community Based Organizations (CBO's) and some private sector institutions (non-traditional outlets).

On the other hand, PSI socially markets the branded version of the female condom as 'Care' Contraceptive Sheath. PSI uses private sector channels such as pharmaceutical and traditional retail outlets to promote female condoms, including innovative channels such as the hair salon network in high focus geographic areas across the country. Sales channels are supported by a range of interpersonal communication activities to generate informed demand and sustained use of female condoms.

3.2 Legal and Policy Framework

The Government of Zimbabwe currently regulates importation, quality assurance and sale of all condoms (male and female) through the Medicines and Allied Substances Control (condom) Regulations of 2005. Under these regulations no condom shall be imported in Zimbabwe without the approval of this authority. As international standards regarding the quality of female condoms are yet to be established by the WHO, the same authority, in consultation with the Ministry of Health and Child Welfare, granted a waiver that, to date, allows the female condom to be brought into Zimbabwe without local quality control.

One of the guiding principles of The National HIV/AIDS Policy states that: 'To limit HIV transmission through sexual intercourse, condoms should be made available, accessible to and affordable for all sexually active persons".

One of the guiding principles of The National HIV/AIDS Policy states that: 'To limit HIV transmission through sexual intercourse, condoms should be made available, accessible to and affordable for all sexually active persons". While the policy does not explicitly address promotion of the female condom, Government made funds available to ensure that all female condoms distributed by public sector facilities are to be given out for free, and those accessed through social marketing are to be highly subsidized.

The Zimbabwe National AIDS Strategic Plan (ZNASP) 2006-2010 emphasizes the urgent need to make female condoms available to certain segments of the population, especially to married women and commercial sex workers.[8]

[7] Government Printing & Publication: Medicines and Allied Substances Control (Condom) Regulations 2005

3.3 Procurement

At the inception of the public sector FC program, procurement of female condoms was exclusively done by ZNFPC, from resources allocated to this cause from the National Budget for the 2 consecutive years 1998 and 1999. However, due to foreign currency shortages, and staff attrition, particularly in the logistics department, the purchasing capacity of ZNFPC was severely affected. In the early years, procurement was supported by several donors, including Swedish International Development Association (Sida), UNAIDS, USAID and DfID, but due to the absence of a long term procurement plan, still did not function smoothly. At present USAID and UNFPA procure female condoms for the public sector and DFID and USAID provide support for social marketing under the overall framework of the Reproductive Health Commodity Security Steering Committee. This committee is chaired by Government and comprises representatives of donors and civil society who provide guidance to the overall contraceptive commodity projection, procurement and distribution process for the entire country.

3.4 Availability

As the Situation Analysis indicated, service providers in the public sector cited limited quantities of supplies as the most significant barrier to programming. Once the limited stocks were received, they were immediately distributed and stock-outs became quite common. Despite a well-developed logistics system for other contraceptive commodities, the shortage of female condom supplies has always meant that accurate projections of requirements could not be made. It was not until 2006, that the RH Commodity Security Steering Committee identified a consortium of partners who have now ensured that sufficient stocks will remain available through the end of 2008. Further commitments are required for 2009-2010.

3.5 Awareness

Knowledge about the female condom is overall limited although not uniform throughout the country. People in areas targeted through social marketing, such as urban and peri-urban areas, appear to have greater awareness compared to rural areas. A correlation is noted between areas with little knowledge regarding the female condom, and low service provider training as well as low stock levels at the nearest facility. A significant push in awareness creation will be essential for a successful program. In this regard, structured linkages with Counseling and Testing, PMTCT, Maternal and Neonatal Health and STI programs, could all provide opportunities for advocacy, awareness and expanded service delivery. Furthermore, every effort must be made to promote dual protection (including both male and female condoms) for all Family Planning users.

Structured linkages with Counseling and Testing, PMTCT, Maternal and Neonatal Health, and STI programs, could all provide opportunities for advocacy, awareness and expanded service delivery.

3.6 Access

Direct delivery of public sector female condoms to consumer access points through DTTU has the potential to be a strong link in the current distribution system. However, due to limited supplies, female condoms are still not readily accessible to users. In some instances, public sector service providers are reported to use arbitrary criteria when rationing supplies.

In contrast, social marketing of female condoms has been more clearly targeted, and effectively distributed to mostly young women in urban and peri-urban areas through a network of hair salons and home meetings.

Besides the Government and quasi-government institutions receiving female condoms from the ZNFPC, some NGOs and CBO's are on the ZNFPC distribution list as non-traditional outlets. The criteria used for selecting these outlets are not clear. However, a number of these organizations that are receiving free female condoms from ZNFPC, especially those that are resource-constrained, find this to be a ready alternative to the PSI's subsidized female condom that sells for less than 2% of the actual

unit cost. Both the Situation Analysis and the Stakeholders meeting confirmed the general perception that the female condom is overly expensive. Despite the relatively low price of the socially marketed female condom, the current pricing is still five times more expensive to the consumer than a single male condom. And, the fact that socially marketed female condom utilization remains high, is evidence that many women are willing to pay for this new form of protection.

3.7 Demand and Utilisation

The ultimate demand for the female condom has to date not been measured, principally because there has never been a time when supplies were available on a consistent basis, and when distribution was based on 'pull' from users. However, the fact that supplies are exhausted soon after delivery is indicative of a latent demand. Service providers estimate the demand to be anything between 3 to 15 times more than is currently being received.

From the Situation Analysis, women cite gender inequalities as well as gender norms, including specific sexuality practices, as barriers to the use of prevention measures such as condoms. Zimbabwe is a patriarchal society and usually it is the men who control sex. There has thus been a need for women to negotiate for safer sex. Refusal of the man to use condoms is a major reason for discontinuing use regardless of the motivation by the woman.

The ultimate demand for the female condom has to date not been measured, principally because there has never been a time when supplies were available on a consistent basis.

In order to improve this situation, UNIFEM is in the process for developing a manual targeted at negotiating skills for adolescents. Also, the social marketing program has utilized interpersonal communication through its hair salon strategy to empower women to negotiate for safer sex.

3.8 Service Provider Training

Original public sector service provider-trainings were intended to spread from higher to lower levels. This strategy however did not develop according to plans.

To date few staff members have been adequately trained to confidently provide information and motivate female condom clients towards sustained use. In 2005 ZNFPC estimated that only 25% of the trained personnel are still in place. Presently, the number is likely to have decreased further due to ongoing staff attrition, promotions, or rotations. The last female condom training in the public sector was done in 2002 and no refresher course has been held since. The training is therefore likely to have gaps in providing information regarding new knowledge in the areas of PMTCT, CT, Anti Retro-viral Treatment (ART) etc. which are critical in addressing HIV/AIDS and Reproductive Health issues.

At the same time, service providers who have already been trained, feel frustrated as a result of insufficient supplies to meet the demand that would have been created by their own efforts, hence do not continue to promote the female condom.

As part of the social marketing program, PSI has developed detailed training programs for care and peer promoters as they function as sales and interpersonal communication agents for the hair salon network, PLWHA groups and Care and Support Organizations. By continuing penetration into CSW groups the peer promoters guide towards informed demand and ensure correct and consistent use of the female condom. Additionally, PSI provides training to external partners e.g. hairdressers, hair salon owners, and focal persons in tertiary colleges, to ensure high levels of motivation are created amongst clients through these channels.

8 MoHCW, ZNFPC, UNFPA and JSI (2005) Female Condom Situation Analysis
9 MoHCW- NACP (1998): Framework For Promoting and Accessing Female Condoms From Public Sector Facilities in Zimbabwe

4. Goal and Outcomes of the Female Condom Strategy

Based upon the Situational Analysis, the Technical Support Group on Condom Programming determined that the overall aim of the program is to contribute to a significant decline in the incidence of STIs and HIV as well as in unintended pregnancies by increasing the number of protected sex acts. The main goal of the Female Condom Strategy is therefore to provide a coordinated framework for a comprehensive and integrated 5-year national female condom program, aimed at increasing availability of, access to and informed demand for female condoms by women and men for prevention of STI/HIV infection and unwanted pregnancy.

The overall aim of the programme is to contribute to a significant decrease in the incidence of STIs and HIV as well as unintended pregnancies by increasing the number of protected sex acts.

The following are the three expected outcomes of the Female Condom Strategy:

1. Increased supply and access to female condoms for sexually active women and men in Zimbabwe.

2. Increased informed demand and utilization of female condoms for the prevention of STI/HIV infection and unwanted pregnancy

3. Strengthened coordination, management and logistical support systems to ensure timely and continuous supply, free distribution and social marketing of female condoms.

5. The Phased Implementation Approach

Following the recommendations generated by the Situation Analysis a three-phased approach to implementing this strategy has been adopted by Stakeholders in Masvingo in March 2006. The rationale for a phased implementation is to allow for a gradual move from uncoordinated distribution to priority group targeting, and eventually to a generalized distribution that will allow every woman who would like to use a female condom, access to it. In addition, the phasing allows time and preparation for incrementally securing adequate resources and supplies, building capacity necessary for strategy implementation as well as incorporate lessons learnt as implementation progresses. Throughout the entire implementation of the strategy the TSG on Condom Programming will assist the Ministry of Health and Child Welfare in assessing and ascertaining the readiness of both infrastructure, funding resources and personnel to move ahead from one phase to the next.

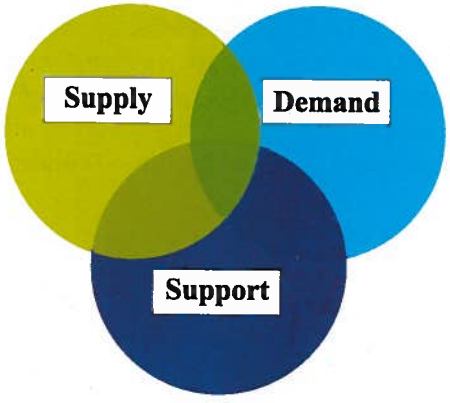
	Phase 1: 2006-7 Consolidation	**Phase 2: 2008 Targeted expansion**	**Phase 3: 2009-10 Generalized distribution**
Target Groups	Married, pregnant and breast feeding women, women in cross-generational sexual relationships, women living with HIV, women in discordant relationships and Menopausal/peri-menopausal women.	Those from phase 1 as well as commercial sex workers and clients at STI clinics. Geographic expansion of existing distribution channels into high-risk areas and "hot zones".	All target groups from phase 1 and 2. In addition, all sexually active clients seeking counseling and testing services at all public sector health care centers and all sexually active persons choosing to use the female condom.
Public Sector Distribution Channels	• Current active public sector distribution sites • FP Clinics • PMTCT • ANC/Family Health Care Clinics • Young women in tertiary colleges. * Health centres where HIV Counseling and Testing is done	• All channels from Phase 1 • STI Clinics. • Community Based Distributors • Condom and Depot Holders • Village/Community Health Workers	• Active distribution sites from phase 1 and 2 • All public sector health care centres.
Social Marketing Sales Channels	• Traditional retail outlets (Pharmacies, supermarkets, tuck-shops, bottle stores) • Hair salons • CSW Groups • PLWHA support groups, Care and support organizations., VCT centres	All channels from Phase 1 Expanded program for patrons of hair salons as well as commercial sex workers at growth points, commercial farming and mining, areas.	Further expansion and consolidation of sales in phases 1 and 2.

[10]These groups have been identified at particularly high risk of STIs including HIV, either as a result of their own behavior or that of their partners. It must be emphasized that the female condom is not intended to substitute or replace the male condom, but to fill in gaps and complement the male condom, resulting in an increased number of protected sex acts.

PHASE I – 2 years

During phase 1, distribution of female condoms will be distributed to all current active sites as well as to all PMTCT sites through the public sector, with a special focus on women in marital unions whose partners do not want to, or are unable to use the male latex condom.
During this phase entry points will principally be Family Health Care Centers and PMTCT Centers, where these are not co-located. MoHCW has nearly 1,400 facilities that offer ANC through the public sector. As at the beginning of 2006, a total of 400 sites were offering comprehensive PMTCT services i.e. PMTCT Counseling, Rapid Testing for HIV, administration of Nevirapine to the mother and the baby etc. A considerable number of these PMTCT centers are already on the DTTU list. The DTTU list shall be reviewed at program inception and outstanding centers will be identified and included on the revised list. The first scale-up activity for the public sector will be to increase the number of female condom outlets by adding PMTCT sites that are currently not on the delivery list, especially sites that offer comprehensive PMTCT services.

PSI will continue scaling up their efforts on active sites, with special focus on married women and young women in cross generational sexual relationships as well as HIV positive women reached through support groups, young women at tertiary colleges, members of Post Test Support Groups and other mobilized groups. Phase 1 is planned for a duration of 2 years, but if the respective goals will have been reached within a more limited timeframe as assessed by the TSG on Condom Programming, adjustments will be made to the start of the implementation of phase 2.



PHASE 2 – 1 year

After phase 1, distribution will gradually expand to include other target groups such as commercial sex workers and clients at STI clinics, and eventually to generalized distribution to all sexually active women who wish to protect themselves from the risk of STI/HIV and unwanted pregnancy, yet are unable to use the male latex condom. Channels will gradually be widened from being mostly health facility based, to community based, by utilizing Community Based Distributors, Condom and Depot Holders as well as Village/Community Health Workers.

Training of service providers at all implementation sites shall be undertaken in order to ensure adequately trained service providers as the phasing process progresses.
Advocacy efforts will be intensified and specific issues such as condom use in marital unions will be made a priority.

PHASE 3 – 4th year and onward

During Phase 3, knowledge of the female condom and its appropriate use will be widespread, distribution to all access points will be consistent and reliable, and all sales will be consolidated.

6. Overview of Strategy Components

Any comprehensive condom strategy should have three main components that are interlinked, interdependent and often synergistic. These components are supply, demand and support. The three form the framework that underpins the expected outcomes of this strategy.

6.1 Supply:

This component entails ensuring consistent availability of female condoms in adequate quantities to users. It involves accurate forecasting of needed supplies, efficient procurement processes that deliver the needed quantities of condoms on time, a distribution system that links supplies to users and quality management to ensure that condoms accessed provide the maximum possible protection from STI/HIV.

6.2 Demand:

While creating a reliable supply of high quality condoms is important, it is equally essential to ensure that the demand for condoms is generated and sustained. Demand creation and sustenance requires that distribution outlets are condom-friendly and that clients are well informed and counseled regarding the use and negotiation of condom use with their partners. In order to achieve this, educational materials about condoms utilizing various media channels shall be used and a community based system that supports use of condoms must be established.

6.3 Support:

In order for the female condom program to have a measurable impact in reducing the sexual transmission of STI/HIV and pregnancy, adequate resources and systems are needed. Human resources must be made available to facilitate the planning, implementation and monitoring of processes and to evaluate impacts. Coordination mechanisms must be established to guide, facilitate and support linkages between programs as well as to monitor implementation in the private, social marketing and public sectors. A monitoring system must be developed to provide information relevant for program development and adaptation.

Policy makers will play an important role in ensuring that sufficient resources are mobilized and allocated for condom programming, as well as in facilitating enactment of policies and regulations that facilitate efficient condom programming, whilst eliminating those that impede progress.

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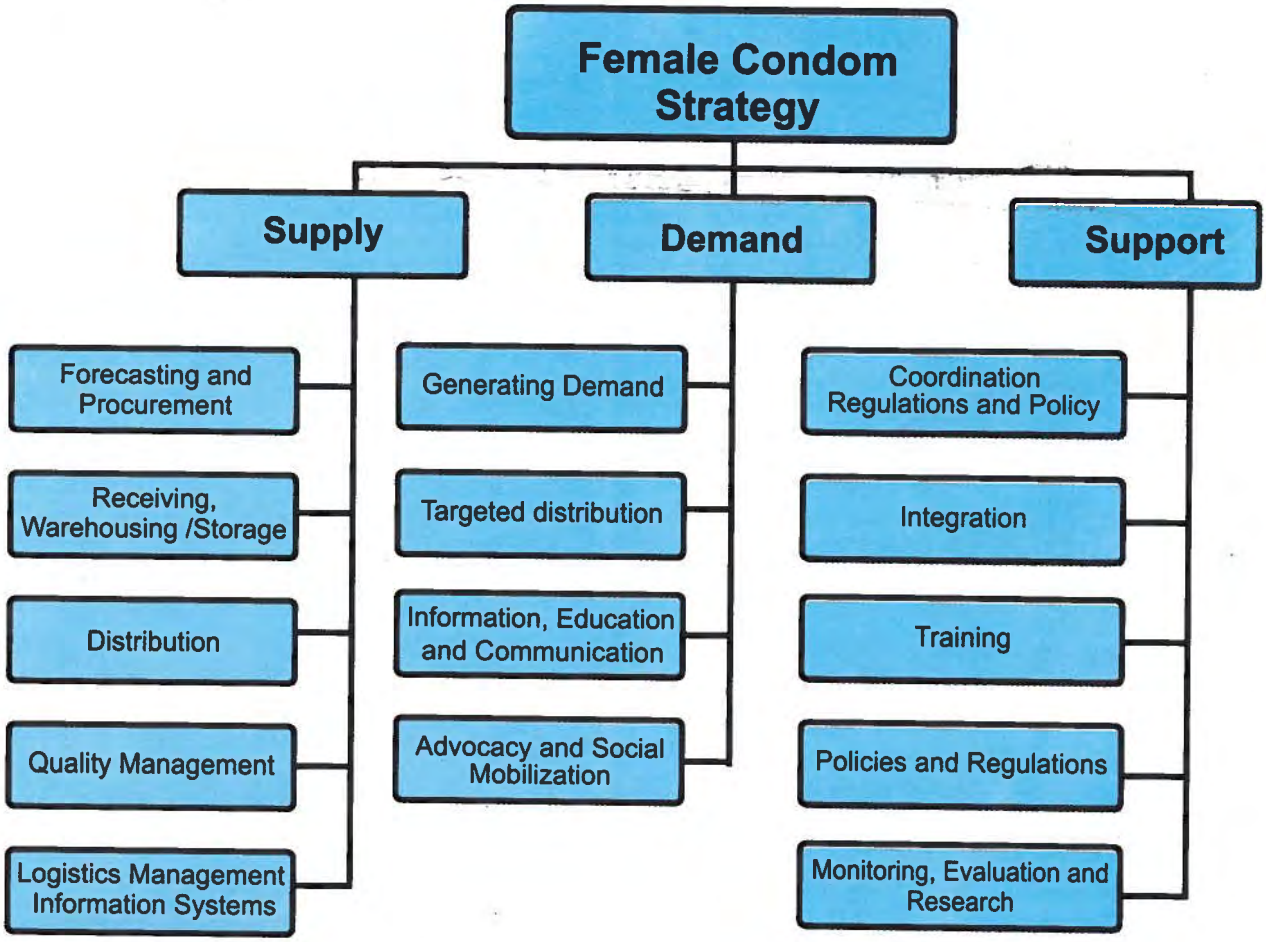
[11] WHO (1995) Condom Promotion for AIDS Prevention – A guide for Policy Makers, Managers and Communicators. Geneva. WHO

Components of the Female Condom Strategy



7. Supply

Outcome 1: Increased availability and access to female condoms for sexually active women and men in Zimbabwe.

Key Issues

- ❑ Demand that far out-weighs the supply
- ❑ Supply-driven rather that demand-driven distribution system

7.1 Forecasting and Procurement

Both social marketing and public sector female condom supplies are dependent on donor support. Currently UNFPA procures female condoms for public sector needs whilst PSI procures its female condom supplies through support from DfID and USAID.
Recently however, donors, specifically USAID and DfID, have expressed interest in supporting procurement of female condoms for both public sector and private sectors. Also currently, the Ministry of Health and Child Welfare pledges to resume allocating a part of the national budget towards procurement of female condoms.

These are welcome developments in an environment that has been characterized by erratic supplies and shortages of female condoms. However, in order to ensure a smooth implementation of all phases of the strategy, commitments of all stakeholders must be coordinated in order to prevent either a saturation, or an interrupted supply of female condoms. Ideally, there must always be 3-4 partners, including 1-2 bilaterals, 1 UN agency and perhaps the Global Fund, to support national contributions. The Ministry of Health and Child Welfare, with Technical Support from the Reproductive Health Commodity Security Committee, must therefore closely supervise such coordination efforts.

In due time, the procurement capacity of ZNFPC should be strengthened sufficiently to enable this organization to take up the procurement function.
The role of JSI Deliver is therefore critical in strengthening the capacity of ZNFPC in the area of Logistics Management.

Procurement of female condoms must increase if the currently foreseen demand is to be met.
At the beginning of Phase 1, therefore, adequate supplies should be allowed to totally fill the distribution pipeline. DTTU will then have a clear starting point to establish baseline data and measure true demand for the commodity.

With time, the procurement capacity of ZNFPC should be strengthened to enable this organization to take up the procurement

Based on available information, including PSI targets for five year pipeline requirements, as well as stocks required at the various levels, the following commodity requirements can be estimated:

Projected female condom requirements[12]

	2006	2007	2008	2009	2010	Total
Public Sector	900,000	1,070,000	1,230,500	1,415.075	1,627,336	6,242,911
Social Marketing	1,515,000	1,461,000	1,534,050	1,610,753	1,691,290	7,812,093
Total	**2,415,000**	**2,530,000**	**2,764,550**	**3,025,828**	**3,318,626**	**14,055,004**

7.2 Receiving, Warehousing and Storage

ZNFPC will be responsible for receiving and storage of all public sector procured female condoms in the country before distribution to peripheral distribution points.

7.3 Distribution

Currently distribution of female condoms to public sector institutions is carried out by ZNFPC, with technical and financial support from JSI Delivery, using the DTTU. This system should be continued and strengthened to meet the expected rise in demand following scaling up efforts. Once the pipeline has been filled, distribution should be based on demand as indicated by the facilities.

At the beginning of Phase I, adequate supplies should be allowed to entirely fill the distribution pipeline. This will allow DTTU to establish baseline data and measure true demand for the commodity.

Public sector service points to which ZNFPC delivers, are divided into two categories, non-traditional and traditional outlets. Non-traditional outlets include private sector and NGO service points.

During the implementation of the strategy, ZNFPC must distribute free condoms to public sector distribution sites, as well as NGOs that are unable to purchase, whilst PSI must focus on the private sector and only those NGOs that will sell the female condom. Public sector sites should include Government, local authority, and public sector workplaces including the National Army, Police, Air Force, National Parks, and Prisons Service health care facilities.

Especially during Phase I, when new distribution sites and target points will be added to the existing ones, it is imperative for JSI Deliver to be flexible and adjust delivery schedules to suit the new targeting approach.

ZNFPC and PSI should collaborate closely in order to ensure that no gaps in coverage are left as ZNFPC phases out from nontraditional outlets to allow social marketing in these distribution areas.

7.4 Quality Management

The Medicines Control Authority of Zimbabwe - a parastatal of the Ministry of Health and Child Welfare – is directly responsible for monitoring the existing policies that regulate current importation of and access to female condoms in Zimbabwe; i.e. the Medicines and Allied Substances Control (Condom) Regulations of 2005. In accordance with these regulations, a waiver granting importation of the specific brand of female condom promoted by the Female Health Company is still in force. For the benefit of the Female Condom Strategy and best interest of existing and new users, the MCAZ must maintain linkages with WHO for updates on new developments in female condom quality assurance, as well as regarding other upcoming female condom brands.

7.5 Logistics Management Information Systems

A critical element of the supply chain is the ability to monitor female condom distribution and utilization. Male and female condom distribution as well as logistics management must therefore be integrated, to ensure that there is a single source of information at all levels to monitor stock requirements as well as program performance of both public and social marketing distribution points.

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[12]Projections are based on trends in 2004 and 2005 distribution, with anticipated increase of 15% per year in both public sector and 5% per year in social marketing programmes, including an estimate for wastage and pipeline requirements. UNFPA and USAID provided supplies in 2005 and 2006, USAID has committed further through 2007, and resources need to be mobilized for 2008 – 2010.

8. Demand

Outcome 2: Increased informed demand for and utilization of female condoms for the prevention of STI/HIV infection and unwanted pregnancy

Key Issues

- ❑ Low level female condom awareness especially in rural areas
- ❑ Apparent demand that has not been quantified
- ❑ Arbitrary methods of targeting in the public sector
- ❑ Overlaps in geographical coverage between social marketing and public sector distribution
- ❑ Lack of tools to negotiate safer sex

8.1 Generating and sustaining demand for female condoms

Awareness, whilst not sufficient to cause behavioral change, is a pre-requisite for behavioral change. Sexually active women and men must be made aware of the risk of not using condoms and must be informed about the female condom and its role in reducing the risk of STIs and unintended pregnancy. They must know where to find female condoms, how to negotiate for its use as well as how to develop a habit for consistent use. Whilst a relatively higher level of female condom awareness has been achieved in urban and peri-urban areas through PSI campaigns, much promotion work is still required in rural areas where the female condom is less known. An attempt to influence female condom use, like any sexual behavior change effort, requires sensitivity and a thorough knowledge of individual behavioral patterns, attitudes as well as cultural and social norms. This is further complicated by the stigma that is associated with condom use in general. Approaches to be used should therefore vary depending on the setting and target group.

The hair salon meeting strategy that was initiated by PSI, supported by strong interpersonal communication, has thus far worked well as it uses familiar surroundings to discuss sensitive matters related to sex with clients, as well as to provide a peer support system for learning about safer sex negotiation.

Public sector programs should therefore explore the applicability of this method in other, and especially rural areas, by using its network of Community-Based Distributors.

8.2 Targeting

Focusing the limited supply of female condoms for specific target groups ensures the greatest public health impact.

In choosing target groups from each of the categories suggested, potential stigmatization of the female condom as a result of careless targeting should be avoided.

In the public sector priority will be given to reaching sexually active women who are at high risk of STI/HIV infection or are already infected yet have partners who are not willing or are unable to use male latex condoms. Primary targets are women in stable or marital relationships. Provider initiated testing and counseling services will also be utilized as a public sector channel. Corresponding with recommendations from the Behavior Change Review, the Behavior Change Strategy and the National AIDS Strategic Plan for 2006 to 2010, condom use in marriage and regular relationships requires special focus, as in these relationships it tends to be much lower compared to use with casual partners. Channels to be used to reach women in this category during each phase are discussed under the section on phasing (see chapter 5). The social marketing sector will prioritize married women living with HIV, women in discordant relations and young women likely to be in cross- generational sex relations. These groups will be reached through the hair salon network, New Start Centers, New Life Centers and support groups of people living with HIV and AIDS (PLWHA).

As lack of male involvement may undermine program efforts, men must be included in programming efforts at every level.

8.3 Promotion and IEC Materials

A number of IEC materials regarding the female condom were developed by the Ministry of Health and Child Welfare, ZNFPC and PSI for service providers as well as for users. However, few of these materials are in vernacular languages and most of them need to be updated and include new knowledge e.g. about the linkages of female condom use with CT, PMTCT or PEP, which at the time of their development were not current issues. All IEC materials must therefore be revised and as well as some must be translated into vernacular languages.

When developing new materials it must be taken into account that Zimbabwe has more of an oral rather than reading tradition, hence the messages to be conveyed need to be concise, direct and clear. Where printed IEC materials are used, the key focus must be to facilitate or stimulate interpersonal communication, and to assist women to talk about and negotiate safer sex with their partners.
A variety of media must be employed including use of electronic audio and audio-visual materials. In line with the BC Strategy, development of IEC materials should be based on the information needs of clients as well as those of service providers. Role models and other community leaders should be utilized to convey messages, especially men who use female condoms with their partners or approve of use of the female condom. Female condom promotion messages should not conflict or undermine use of the male condom, but rather emphasize complementarities of the two methods.

Demonstration models (pelvis/vagina) should be procured, not only for training purposes, but also for use by service providers during motivation sessions or other client support consultations. The ideal situation would be for each CBD and Condom Holders to have a model. However, costs may be prohibitive.

8.4 Advocacy and social mobilization

Advocacy played a critical role in facilitating introduction of the female condom and continues to have a role. However, the activities of advocacy organizations such as women's groups, need to be dynamic and consequently shift focus to generate and sustain demand as well as cultivate acceptance of condoms in general, in particular of the female condom, and in marital relationships. Community and traditional and church leaders must be a key target for advocacy efforts. Organizations responsible for advocacy shall forge linkages with NAC structures regarding their community mobilization for HIV prevention and the female condom should be part of the overall sexual illness prevention package on offer. It is imperative to avoid creating another advocacy forum since most of the advocacy organizations are members of the National Gender Forum.

9. Support

Outcome 3: Strengthened coordination, management and logistical support systems to ensure timely and continuous supply, distribution/sales of female condoms.

Key Issues:

- ❑ Uncoordinated condom programming between social marketing and public sectors
- ❑ Overlaps in geographical coverage in female condom programming
- ❑ Perceived inequity in pricing of socially marketed female and male condoms

9.1 Coordination

When established, the Ministry of Health and Child Welfare was equipped with an office for condom programming coordination. This office however lost all its staff members in 2003 and has not recuperated since because of public service salary scales that are much too low. UNFPA has agreed to a request from the Ministry of Health and Child Welfare, AIDS and TB Unit to support the re-establishment of essential positions, after which the office will be responsible and collaborating with the relevant sector ministries, MCAZ, ZNFPC, PSI, donors, and other partners, in coordinating the overall national five-year male and female condom strategy for Zimbabwe and in providing support to all implementing partners.

The success of female condom sales by PSI is an indication that the female condom should not be viewed as a product but as a program where distribution and training are very closely linked.

With support and guidance of the TSG, the office will facilitate close collaboration between private, social marketing, NGO sectors, as well as the donor community in upholding an integrated female condom program. The office will also provide help with the implementation of communication programs for public education to promote acceptance, correct and consistent use of male and female condoms within the context of the National BC Strategy and National Strategic Framework.

Besides providing support to the Ministry of Health and Child Welfare, ZNFPC must receive institutional support to address their high staff turnover, since continued staff attrition is likely to outstrip the gains that will be achieved through training and other program investments. The cost of staff support to ZNFPC should therefore be weighed against the costs associated with introducing a new technology, such as the female condom.

The activities of advocacy organizations need to be dynamic and consequently shift focus to generate and sustain demand.

9.2 Integration of the female condom program into existing HIV/AIDS and Reproductive Health programs

Female condoms are currently being integrated successfully into Home-Based Care, VCT, PMTCT, FP and general counseling programs, but at a limited scale. Deliberate efforts should therefore be made by the Ministry of Health and Child Welfare (AIDS and TB Unit) at the policy level, to integrate condoms into Reproductive Health programs and at all possible levels of the HIV/AIDS response, i.e. Home-Based Care, CT, ART, PMTCT, and Post Test Support Services etc.

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[13] MoHCW (2004) The HIV Epidemic in Zimbabwe – Background, Projections, Impact and Strategic Response

[14] ibid

9.3 Training of service providers

Since the female condom is a method that requires strong service provider and peer support, most of the trained service providers either have left the service or feel de-motivated to promote this method because of the inconsistent delivery of supplies.

The Female Condom Situation Analysis recommends that service providers are considered as another target group for end-user training and distribution. Service providers are easy to access, and directly protecting them against HIV will contribute to a more effective health system. Additionally, those who are effective users are more likely to be effective educators of the method.

Service providers will therefore be trained and equipped with the necessary skills and knowledge to effectively communicate information about the female condom. Candidates for training should include trainers from nurse training institutions to ensure that the pre-service training of nurses includes the female condom among other contraceptive and STI prevention methods. Training must be standardized and a training manual must be developed for use in both public and social marketing sectors. This manual must be comprehensive and thus include all aspects of condom programming including monitoring and evaluation.

The female condom is a method that requires strong service provider and peer support, due to the socio-cultural challenges associated with negotiating safer sex, as well as the motivation required to utilize condoms consistently and correctly.

Initial training should focus on training of trainers who will ensure that training is spread to lower levels in synchrony with the phasing approach. The ZNFPC will be responsible for public sector training whilst PSI focuses on workplaces, NGOs and CBOs. Joint training is, where possible, encouraged in order to promote resource sharing. Trainers from both the social marketing and the public sector must be encouraged to network and share notes to enhance quality.

After all the necessary providers will have been trained, a re-assessment of provider training needs will be done and if necessary, a refresher course will be done in order to address the needs of providers adequately.

9.4 Policies and Regulations

9.4.1 Quality Assurance

Oversight of policy implementation will be the responsibility of the Ministry of Health and Child Welfare, while further support will be received from MCAZ, the National AIDS Council and ZNFPC.

9.4.2 Female condom re-use

One critical policy issue relates to female condom re-use. Based on extensive consultation, current policy suggests that a female condom should not be used more than once. However, its re-use was reported by 30 (2.2%) of the 1,391 women involved in the female condom pilot study carried out by the Ministry of Health in 1998, despite instructions that the product is meant only for single use. Re-use has been reported in other studies in South Africa, Bangladesh etc., hence there are good reasons to suspect that re-use of the product does occur, although the exact extent to which this is prevalent is not known. The World Health Organization does not recommend re-use of the female condom, but developed a protocol that minimize the risk associated with their re-use. The Ministry of Health and Child Welfare in Zimbabwe, in consultation with stakeholders that included women's groups, unanimously agreed in 2002, NOT to adopt this protocol, but rather to commit itself to mobilizing resources to meet female condom needs, but only for single use. Simultaneously, civil society must educate women against re-use of the female condom. Messages against re-use should be backed by and reinforced through appropriate IEC materials.

Based on extensive consultation, current policy suggests that a female condom should not be used more than once.

9.4.3 Pricing

Despite a cost price at US$0.03 and US$0.72 respectively, both male and female condoms are issued free to users in the public sector. For social marketing, both male and female condoms are highly subsidized, selling at Z$3.00 for a packet of two female condoms. Pricing in the social marketing sector, besides serving negligible cost recovery purposes, is meant to instill a sense of responsibility and commitment to using the product once it is purchased.

9.5 Monitoring and Evaluation

Monitoring and evaluation are a critical part of the strategy. The system will be expected to generate data relevant for guiding decision making for program improvement and adaptation. A good monitoring and evaluation system will be useful for making available information necessary for resource mobilization.

Whilst each of the implementing partners will develop a monitoring and evaluation plan, the Ministry of Health and Child Welfare - AIDS & TB Unit shall, from the onset, develop an overall M&E plan based on consolidated data from implementing partners.

In addition to the quantity of condoms made available in the country and distributed from service delivery points, geographic coverage of the female condom program should be assessed, as well as data collected on current female condom users, in order to determine if program efforts shift. The ZDHS data should continue to be used to monitor trends and characteristics of persons using the female condom. These data can help programs demonstrate the impact of female condom programming on the HIV/AIDS epidemic over time.

Essential indicators have been outlined below for national level data. At program level however, implementing partners may have more output indicators for measuring progress.

Data required, possible sources and relevant indicators

Component to be monitored	Source of Data	Indicators	Reporting Frequency	Organization Responsible
Availability ❑ **National** * **Peripheral**	Procurement Records ZNFPC, PSI Facility survey NAC activity Reporting	❑ Number of female condoms available nationally per sexually active person ❑ Number of female condoms in stock * Number of days female condoms are out of stock in a month	Yearly 2 Yearly Quarterly	MoHCW MoHCW NAC
Distribution	Monthly facility returns Public sector T5 Form	Number of female condoms distributed from public sector and other non-traditional condom outlets	Monthly	NAC MoHCW
Service utilisation	NAC activity Reporting Form	❑ Number of Service Delivery points distributing female condoms * Number of female condoms distributed	Quarterly	NAC
Condom Utilisation	ZDHS	❑ Proportion of women and men who used a female condom at last sex with cohabiting partner * Proportion of women and men who used a female condom at last sex with non-cohabiting partner	5 Yearly	MoHCW ZNFPC PSI
Knowledge, Awareness and Risk perception	ZDHS	❑ Proportion of women and men who know where a female condom can be obtained	5 Yearly	MoHCW ZNFPC PSI
Training of Service Providers ❑ **National** ❑ **Provincial** ❑ **District** * **Sub-district**	Program reports ZNFPC /PSI	Number of service providers trained in use of and interpersonal communication on the female condom	Quarterly	MoHCW ZNFPC PSI

Currently, PSI monitors distribution of female condoms by geographic area (urban, rural, mining area, growth point, border area, encampment area, commercial faming area, resettlement area) and administration area (province, district), by type of channel related to a particular interpersonal communications activity, and by population type through comprehensive MIS and Geographic Information Systems. This ensures maximum coverage and impact in priority areas.

PSI has regularly conducted distribution surveys to measure product availability and access by geographic areas and population groups. Thus availability and accessibility at district and provincial levels as well as in high priority areas can be correctly assessed and areas for improvement identified.

PSI also regularly conducts assessment studies of its distribution network (e.g. the 2002 and 2004 Hair Salon Assessment Study) to measure the potential of its innovative channel in ensuring sustained use of female condoms. This assessment will be extended to include the new distribution channels that were developed in 2005 and 2006.

9.6 Research

Research must be an essential part of the female condom strategy. The Ministry of Health and Child Welfare, with guidance from the TSG on Condom Programming, will identify priority research areas and link those with relevant research institutions such as the University of Zimbabwe Department of Obstetrics and Gynecology and Community Medicine, and the Women's University or Zimbabwe Open University. Areas of research will be identified through questions raised by the Situation Analysis, the Behavior Change Review or the Strategy Mid Term Review. Some of the areas recommended as requiring operational research are: triple protection and female condom re-use.

Of particular importance, is the need to ensure that findings of research are utilized to improve programming and that proper documentation is disseminated.

9.7 Resource Mobilization

Considering constraints associated with the availability of foreign currency the success of this strategy is dependent on the availability of donor support, especially for external costs such as procurement.

With support from UNFPA, MoHCW shall seek support from the donor community for the procurement and distribution of female condoms to supplement Government resources. For the strategy to be successful, it is critical that an effective monitoring and evaluation system is put in place to ensure that program outcomes and impacts are demonstrated.
The National AIDS Council must set aside funds to especially cover internal costs of programming e.g. training, distribution etc.

10. Roles of Different Partners in the Strategy

10.1 Ministry of Health and Child Welfare

The Ministry of Health and Child Welfare will collaborate with relevant stakeholders and oversee the overall implementation of the strategy. Each of these stakeholders will have a critical role to play, most of which are stipulated below. The Ministry of Health and Child Welfare shall coordinate policy development and operationalisation regarding the female condom as well as work together with National AIDS Council and other departments of government e.g. the Ministry of Finance, in mobilizing required resources. With technical support from the TSG on Condom Programming, the Ministry of Health and Child Welfare shall in addition, facilitate networking and sharing of lessons learnt among stakeholders.

10.2 Zimbabwe National Family Planning Council

- ❑ Develop organizational implementation plans and implement accordingly
- ❑ Forecast female condom requirements for the public sector
- ❑ Receive, store and distribute female condoms to public sector service delivery points
- ❑ Organize Training of Trainers and service providers in the public sector in accordance to the guidelines for each phase
- ❑ Develop IEC materials relevant to users and service providers.
- ❑ Compile and distribute other data, and provide quarterly reports to MoHCW
- ❑ Deliver service to clients
- ❑ Provide client education and promote the acceptance and utilization of female condoms

10.3 Medical Control Authority of Zimbabwe

- ❑ Monitor implementation of the existing policy that currently regulates importation of and access to female condoms
- ❑ Maintain linkages with WHO for updates regarding new developments of female condom quality assurance
- ❑ Keep updated and advise TSG and the Ministry of Health and Child Welfare about upcoming developments regarding female condom quality assurance as well as other upcoming female condom brands

10.4 National AIDS Council

- ❑ Organize Community mobilization for acceptance of female condom and other prevention services
- ❑ Provide technical assistance and financial support
- ❑ Collect quarterly reports from stakeholders

10.5 John Snow International/Deliver

- ❑ Provide technical and financial support for the forecasting of female condom requirements and distribution
- ❑ Link with MoHCW and donors to ensure timely procurement and consistent availability and delivery of female condoms
- ❑ Provide technical support for the M&E component to MoHCW

10.6 Population Services International

- ❑ Procure and distribute female condoms through identified social marketing channels
- ❑ Organize Social Marketing of female condoms
- ❑ Collaborate with relevant partners in relation to behavior change, promotion of condoms and other innovative HIV prevention approaches.
- ❑ Develop IEC materials and distribute to specific identified target groups
- ❑ Develop product related communication materials for different target groups
- ❑ Map high-risk areas, population and distribution coverage.

- Monitor coverage, access and equity of access for the social marketing and public sector programs.

10.7 Bilateral community of Donors

Provide financial support, especially for procurement, shipment and distribution of condoms, as well as offer support to training programs.

10.8 United Nations Agencies

- UNFPA will provide technical support and guidance related to condom programming to the Ministry of Health and Child Welfare and other implementing partners. Where possible, UNFPA will provide limited financial support.
- Other UN agencies will provide technical support in relevant areas of expertise related to female condom programming

10.9 Non Governmental Organizations

NGOs, especially those working with both men and women as well as community leaders e.g. Padare, Women and AIDS Support Network, Women's Action Group, and Musasa Project, will be instrumental in carrying out advocacy activities in order to foster acceptance of the female condom. In phase 2 and 3 these organizations will, where they exist, also serve as a distribution point through their provincial and district chapters.

11. Scaling up the National Female Condom Strategy

The Ministry of Health and Child Welfare shall disseminate the strategy to relevant stakehold Implementing partners in this strategy will be expected to develop implementation plans within context of one national costed workplan. The MoHCW, with support from the TSG, will ensure t all activities related to the national strategy are coordinated and will contribute toward the overall g and outcomes.

An annual review will take place within the context of the Zimbabwe National AIDS Strategic Pl n. as well as of an annual review of the national Reproductive Health Program. Additionally, a form al mid-term and end-of term review of the Female Condom Strategy involving all stakeholders, will be held.

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